Chapter Four

Medicaid Managed Care Programs

Chapter Overview

Introduction

North Carolina Medicaid participates in four managed care programs: Carolina ACCESS, ACCESS II and III, and HMO Risk Contracting.

As Medicaid managed care continues to expand and evolve, providers will be updated through the Medicaid Bulletin.

In This Chapter

This chapter contains:

Carolina ACCESS (CA)

Overview

Carolina ACCESS (CA) is Medicaid's primary care case management program. CA links Medicaid recipients with primary care providers (PCPs) who act as gatekeepers in providing and coordinating recipient health care.

The Carolina ACCESS program began as a demonstration project in April 1991 through the cooperative efforts of the North Carolina Department of Human resources, Division of Medical Assistance (DMA), and the North Carolina Foundation for Alternative Health Programs. Partial funding was provided through a grant from the Kate B. Reynolds Health Care Trust. At the end of the demonstration period, Carolina ACCESS became a state-administered program through the Division of Medical Assistance. There are approximately 500,000 recipients enrolled in managed care programs in North Carolina.

Enrollment in CA is mandatory for certain Medicaid recipients as indicated in the Recipient Enrollment block.

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Carolina ACCESS (CA), Continued

Participating Counties

On January 1, 1999 Medicaid managed care expanded to all 100 counties, with Carolina ACCESS active in 99 counties, one (1) county with mandatory HMO enrollment (Health Care Connection in Mecklenburg), and five (5) counties with an HMO option available in addition to Carolina ACCESS.

Recipient Enrollment

Recipients are enrolled in CA at the time of their initial application or redetermination of eligibility. Each family member may have a different PCP, if they so choose. (For example, a mother may choose an OB/GYN provider for herself and a pediatrician for her children.)

The Carolina ACCESS program benefits and requirements must be explained to all mandatory and optional Medicaid applicants and recipients in all counties except Mecklenburg.

MANDATORY AID PROGRAMS		**OPTIONAL AID PROGRAMS**		**EXCLUDED [1]**	
AAF	Work First Family Assistance	HSF	Medicaid Non-Title IVE Foster Care Children	MQB	Medicare Qualified Beneficiaries
MAB [2] & MAD	Blind & Disabled	IAS	Medicaid Title IVE Adoption Subsidy Foster Care Children	MRF	Medicaid for Refugees
MAF	Medicaid Families and Children	MPW	Medicaid Pregnant Woman (pink card)	RRF	Refugee Assistance
MIC	Medicaid Infants and Children	Dual	Any Medicaid recipient who is also eligible for Medicare (sometimes referred to as "dually" eligible)	SAA	Special Assistance to the Aged
MSB	Medicaid for Special Assistance to the Blind	MAA	Aid to the Aged (also eligible for Medicare)	SCD	Certain Disabled (money without Medicaid)
SAD	Special Assistance to the Disabled			"D" Status	Any recipient in deductible ("D") status rather than authorized ("A") status
				All illegal Alien Medicaid Classifications	

[1] All Nursing facility residents and ICF-MR recipients are excluded.
[2] Recipients in the MAA, MAB or MAD category are optional if they have Medicare (dual eligibles).
Note: CAP services are exempt from requiring a PCP authorization.

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Carolina ACCESS (CA), Continued

Copayments

CA recipients are responsible for all copayments required by Medicaid guidelines.

Newborn Enrollment

Newborns of Medicaid-eligible mothers are automatically eligible for Medicaid from the date of birth. The eligibility worker must be notified of the birth and will contact the caretaker for enrollment in the CA program.

CA is never retroactive; therefore, the newborn will not be a CA member until release from the hospital and selection of a PCP.

Services That Do Not Require Authorization From PCP

Carolina ACCESS enrollees may receive the following services from any qualified provider who accepts Medicaid (subject to Medicaid coverage policies and limitations) without first obtaining authorization from their primary care physician:

- ambulance
- anesthesiology
- at-risk case management
- CAP services
- certified nurse anesthetist
- child care coordination
- dental
- services provided by developmental evaluation centers
- emergency medical services (as defined by the Carolina ACCESS emergency room reimbursement policy)
- eye care services (limited to CPT codes: 92002, 92004, 92012, 92014, and diagnosis codes related to conjunctivitis: 370.3, 370.4, 372.0, 372.1, 372.2, 372.3)
- family planning (including Norplant)
- health department services
- hearing aids (under age 21)
- HIV case management services
- hospice
- independent and hospital lab services
- maternity care coordination
- optical supplies/visual aids
- pathology services
- pharmacy
- psychiatric/mental health (psychiatrists, psychiatric hospitals, area mental health programs, psychiatric facilities, and inpatient and outpatient services billed with a hospital provider number with a primary or secondary diagnosis of 290-319)
- radiology (only includes services billed under a radiologist provider number)
- services provided by schools and Head Start programs

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Carolina ACCESS (CA), Continued

The Referral Process	The PCP is expected to assure each enrollee's access to necessary health care by arranging for after hours coverage and authorizing referrals for specialty care. The process of referring a patient to a specialist is simple to facilitate access to the most appropriate and cost effective care. Referrals can be made by telephone. Written authorization is not required. • The PCP's authorization number is provided to the specialist, who then includes this number in block 19 of the HCFA 1500 claim form • The PCP may refer for only one (1) visit or for the course of treatment for the diagnosis. If the PCP authorizes multiple visits, the specialist does not need to obtain authorization for each treatment visit • If the specialist needs to refer the patient to a second provider for the same diagnosis, the specialist requests approval from the PCP and then provides the authorization number to that second provider • The PCP may authorize care retroactively; however, it is at the discretion of the PCP to do so • Hospital care, inpatient or outpatient, requires authorization from the PCP. The PCP's authorization number is provided to the hospital, who then includes this number in block 11 of the UB-92.

Emergency Room Reimbursement Policy	The Carolina ACCESS emergency room reimbursement policy establishes criteria for Medicaid reimbursement of emergency room services. The policy covers medical screening exams and the stabilization of identified emergencies without regard to prior authorization 24 hours per day, 7 days a week. The list of identified emergencies is not exclusive of other conditions determined to be an emergency though retrospective medical record review. **Note: This policy also applies to the Carolina ACCESS II and III programs.** 1. Treatment in the emergency room for nonemergent care is not generally covered. • A nonemergent service rendered Monday through Friday, 8 a.m. to 5 p.m. will result in a denied claim • Medicaid may be billed a medical screening exam fee of $25.16. The screening fee (W9922) must be filed on the HCFA-1500 • Laboratory and other tests needed to evaluate the existence of an emergent condition may be covered through retrospective medical record review based upon "prudent layperson" standards and medical necessity criteria. • Documentation may be submitted to Carolina ACCESS for retrospective medical record review (See Attachment A for form) and must include a copy of the completed Retrospective Medical Record Review as a cover sheet, the denied claim, remittance advice (RA), and medical records to demonstrate medical necessity. The quality management staff reviews the documentation with all recommended denials receiving a physician review. The review decision is based upon "prudent layperson" criteria and accepted standards for medical practice as defined by COBRA/EMTALA/BBA Federal regulations. If approved for payment, the claims are forwarded to EDS. The hospital is notified of any payment denials. See Appendix B for the Managed Care section phone number and address

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Carolina ACCESS (CA), Continued

Emergency Room Reimbursement Policy, (continued)

2. The primary care provider (PCP) may authorize payment for nonemergent treatment after hours (5 p.m. to 8 a.m., Monday through Friday and 24 hours on weekends) and should be contacted for an authorization number following the medical screening exam. Authorized claims for nonemergent care require the authorization number in form locator 11 on the UB-92 and in form locator 19 on the HCFA-1500.

   Retrospective authorization (i.e. after the service has been provided to the recipient) may be provided at the discretion of the PCP and is determined by individual review for medical necessity.

For Coding: Carolina ACCESS emergency room claims are edited against form locator 76 "Principal and Other Diagnosis" in addition to form locators 68-75. If an emergency code, as defined in this policy, appears in any of these form locators the claim will process and will not require authorization. Place the **presenting diagnosis code** in form locator 76. The American Hospital Association has recommended use of this form locator be used when a presenting diagnosis is the triggering diagnosis for payment.

What To Do If the Emergency Room Staff Cannot Reach PCP

All Carolina ACCESS PCPs agree, as participants in the CA program, to provide after-hours medical advice, 24 hours a day, seven days a week. Should the PCP not be available, hospital staff should document this in the medical record and send the claim to EDS. If the claim denies, the Retrospective Review process should be followed. (See Attachment A) PCPs are not allowed to automatically refer the recipient to the emergency room for after-hours coverage.

Reconsiderations for Treatment in the Emergency Room

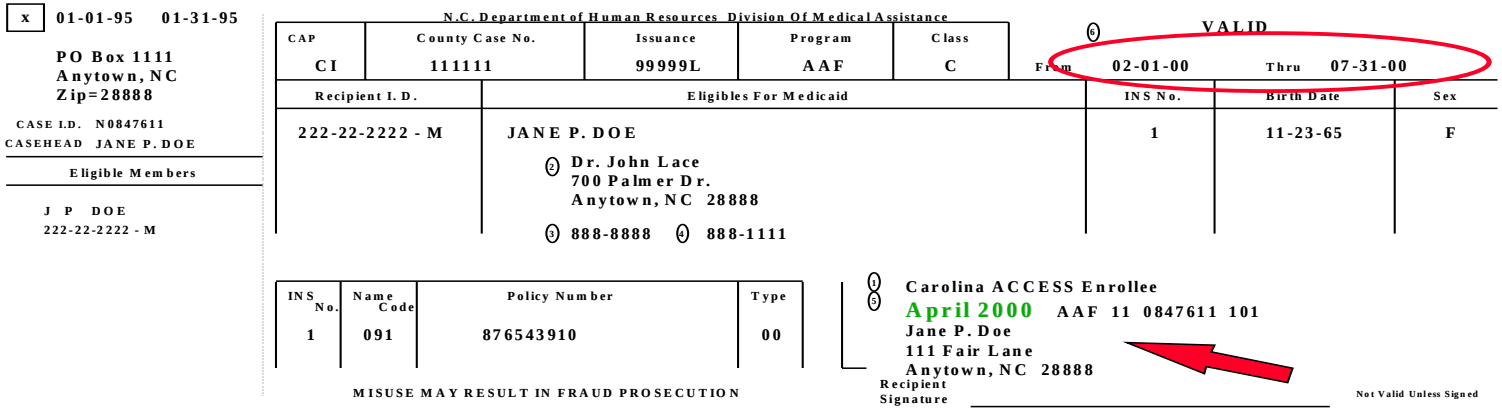
If the emergency room is unable to obtain authorization for payment from the PCP or the claim denies as not a "true emergency," the claim can be reconsidered for payment with documentation that supports the medical necessity for treatment. The CA Medical Director will review the claim and medical records to determine if the services are medically necessary.

Identifying CA Enrollees

Information on a recipient's MID card identifies CA enrollees. "Carolina ACCESS Enrollee" appears on the card along with the name, address, daytime and after-hours telephone numbers of the PCP. See the following MID card example:

Continued on next page

Medicaid Identification Card



1. Identifies the recipient as a Carolina ACCESS enrollee.
2. Identifies the name and address of the Primary Care Physician (PCP).
3. Identifies the daytime phone number of the PCP.
4. Identifies the after hours phone number of the PCP.
5. Issuance month - The month in which the card was issued. This month the recipient is linked with the provider listed in #2 above.
6. Valid Medicaid eligibility dates - The dates the recipient is Medicaid eligible. These dates may not correspond with Carolina ACCESS eligibility dates and linkage with the PCP. For this, it is important to look at the issuance month (#5).

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Carolina ACCESS (CA), Continued

Additional Information

Carolina ACCESS will supply a handbook of their program and policies upon request. See Appendix B for phone number. There is a Managed Care representative at the department of social services or health department in each county that participates in CA. This person is an excellent resource for any provider questions regarding Carolina ACCESS.

ACCESS II And III

ACCESS II and III	ACCESS II and III are primary care programs designed to bring together providers to cooperatively plan for meeting patient needs and to strengthen the community health care delivery infrastructure. ACCESS II and III plans: • utilize local collaboration and community focus to better meet the needs of the Medicaid population • population based and identifying at-risk enrollees • developing and measuring defined budget and utilization targets and quality indicators • strengthening the community "safety net" that is in place to serve the expanding indigent population ACCESS II, active in 23 counties, includes local networks comprised of key Medicaid providers who have agreed to work together to develop the care management systems and supports that are needed to manage enrollee care. This model also includes a statewide network of large Carolina ACCESS practices who have agreed to work together to develop collaborative systems for managing care. ACCESS III, active in 2 counties, includes countywide plans that are community partnerships involving physician, hospitals, health departments, departments of social services, and other community providers. Networks are assuming responsibility for managing the care of eligible Medicaid populations in the entire county.

HMO Risk Contracting

Overview

DMA contracts with authorized HMOs to provide and coordinate medical services for specified county Medicaid recipients.

Health Care Connection is a mandatory Medicaid managed care program in Mecklenburg County.

HMO options are available in the following counties on a voluntary basis:

- Gaston
- Triad Area: Davidson, Forsyth, Guilford, Rockingham

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HMO Risk Contracting, Continued

Who Participates?

The following Medicaid categories participate:

- Work First Family Assistance (WFFA)
- Medicaid to Families with Dependent Children (MAF)
- Medicaid–Infants and Children (MIC)
- Medicaid–Pregnant Women (MPW) (optional)
- Medical Assistance for Disabled (MAD)–under 65 years of age and not receiving Medicare
- Medicaid–Aid to the Blind (MAB) Medicaid–Special Assistance to the Blind (MSB)–under 65 years of age and not receiving Medicare
- Adult Care Home Residents (SAD)
- Foster Adopted Children–HSF; IAS (optional)

Dual eligible participants are ineligible for HMO enrollment. Long term care residents and recipients with an unmet Medicaid deductible are ineligible for participation.

Risk Contracting Health Care Options

Medicaid recipients who participate in HMO Risk Contracting are required to select a managed care plan from one of the following:

- United Healthcare of North Carolina (UHCNC)
- The Wellness Plan (WP)
- C. W. Williams Health Center (CWWHC)
- Principle Health Care of the Carolinas

See chart for options available in participating counties.

COUNTIES PARTICIPATING	HEALTH CARE OPTIONS			
	PHC	WP	CWWHC	UHCNC
Davidson				✔
Forsyth				✔
Gaston		✔		
Guilford				✔
Mecklenburg	✔	✔	✔	✔
Rockingham				✔

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HMO Risk Contracting, Continued

Benefits

HMOs are required to offer a basic set of benefits called "in-plan benefits" which, at a minimum, must be as comprehensive in range and scope as the benefits offered under fee-for-service Medicaid.

In-plan benefits are covered under the capitation rate paid to HMOs, so authorization and reimbursement for these services must be sought from the HMO. There are no copayments for any in-plan benefits. In-plan benefits include:

Adult Health Screening
Ambulance
Chiropractic Services
Diagnostic Services
Dialysis
Durable Medical Equipment
Emergency Room
Eye Care
Family Planning Services and Supplies
Health Check (EPSDT)
Hearing Aids
Home Health
Home Infusion Therapy
Hospice
Inpatient Hospital (except for Mental Health and Substance Abuse)
Clinic Services (except for Mental Health and Substance Abuse)
Laboratory Services
Midwife
Occupational Therapy
Optical Supplies
Outpatient Hospital
Physical Therapy
Podiatry
Private Duty Nursing
Prosthetic/Orthotics
Radiology Services
Respiration Therapy
Speech Therapy
Sterilization
Total Parenteral Nutrition
Physician Services including Physician Assistants and Family Nurse Practitioners (except for mental health and substance abuse)

Out-of-Plan Benefits

Out-of-plan benefits are not included in the capitation rates and are reimbursed on a fee-for-service basis. Recipients continue to use their Medicaid card for these services and are responsible for any applicable copayments. Out-of-plan benefits include:

At-Risk Case Management
Community Alternatives Program Services
Child Service Coordination
DEC Services (OT,ST,PT) ages 0-5
Dental
HIV Case Management
ICF/MR
Maternity Care Coordination
Prescription Drugs
Substance Abuse
Mental Health–Inpatient and Outpatient
DSS Nonemergency Transportation
Nursing Care–Skilled or Intermediate
Personal Care Services
School-Related and Head Start Therapies

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HMO Risk Contracting, Continued

Inpatient Hospital Services

Recipients who are hospital inpatients when they enroll in an HMO through Medicaid or who transfer plans have all hospital inpatient services, and any service directly related to inpatient care, covered by the plan from which they are disenrolling until discharged from the hospital.

When the "old" plan is fee-for-service Medicaid, reimbursement for inpatient care is made through DMA's Managed Care Unit. When the "old plan" is an HMO, reimbursement is made through the HMO.

Newborn Enrollment

Newborns of health plan members are automatically enrolled and covered by the mother's plan, effective from the date of the child's birth.

Emergencies

Plans are responsible for covering all medical services required to treat a member's emergency medical condition, 24 hours a day, 7 days a week. Emergency medical conditions may be treated at any medical facility and are to be based on the medical signs and symptoms of the condition upon initial presentation. Plans are responsible for educating their members on the appropriate use of emergency services.

Verifying Enrollment

The MID card will show the HMO's name, address, and telephone number. Enrolled recipients also receive a member ID card from the plan. The MID card example on the following page shows this information.
An HMO may also be verified through the Voice Inquiry System. See Appendix B.

Additional Information

You can obtain additional information on Health Care Connection and voluntary HMO enrollment directly from Health Care Connection. See Appendix B.

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(SEE INSTRUCTIONS ON BACK)

Medicaid Identification Card

X 07-1-00 07-31-00

PO Box 1111
Anytown, NC
Zip=28888

Case I.D. N0847611
Casehead Jane P. Doe

Eligible Members

JP Doe
222-22-2222-M

N.C. Division of Human Resources Division of Medical Assistance

CAP	County Case No.	Issuance	Program	Class
CI	111111	99999L	MAF	C

VALID (1) From 02-01-00 Thru 07-31-00

Recipient I.D.	Eligibles for Medicaid	INS No.	Birth Date	Sex
222-22-2222-M	Jane P. Doe	1	11-23-65	F

(2) Your HMO Health Choice
112 Open Road
Anytown, NC 28396

(3) 1-800-296-1000

INSURANCE DATA

INS No.	Name Code	Policy Number	Type
1	091	876534910	00

MISUSE MAY RESULT IN FRAUD PROSECUTION

(4) PREPAID HEALTH PLAN ENROLLEE
(5) July 2000 AAF (6) 60 0847611 101
Jane P. Doe
111 Fair Lane
Anytown, NC 288888

Recipient Signature _____ Not Valid Unless Signed

1. The dates the recipient is first linked with the current Health Care Option. From - the date the recipient first enrolled with current Health Care Option; Thru - the last day of the current month.
2. Identifies the name and address of the Health Care Option.
3. Identifies the Member Services phone number.
4. Identifies the recipient as a Prepaid Health Plan Enrollee.
5. Issuance month - The month in which the card was issued. This month the recipient is linked with the Health Care Option listed in #2 above.
6. Identifies the county from which Medicaid benefits are received. For example, this recipient is served through Mecklenburg County.

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Carolina ACCESS Emergency Room Retrospective Medical Record Review Form

Patient Name

Patient Medicaid ID # Date of Birth

Date of Service Time of Service

Day of Week

Place of Service

Diagnosis Code #1

Diagnosis Code #2

Diagnosis Code #3

Diagnosis Code #4

Diagnosis Code #5

☐ Presenting symptoms met Prudent Layperson standard (as defined in BBA) for emergency.

☐ Illness severity required emergency treatment

☐ Ancillary diagnostic testing required to determine emergency treatment requirements

☐ PCP not available when contact was attempted on_____(Date)by _____(Hospital Personnel)

☐ PCP would not authorize ER visit when telephoned on_____(Date)by_____(PCP Personnel)

☐ PCP call not required - Hospital/PCP written protocol for specific medical condition exists

☐ Other, please explain

Return To:

Managed Care
Division of Medical Assistance
Attn: Retrospective Medical Record Review
2516 Mail Service Center
Raleigh, NC 27699-2516

Please group UB-92 and HCFA-1500 claim forms with the medical record if physician and hospital services are to be reviewed. Incomplete records will be returned.

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